## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/18/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185330	B. WING			10/0	05/2021
NAME OF PROVIDER OR SUPPLIER  CAMPBELLSVILLE NURSING AND REHABILITATION CENTER				19	TREET ADDRESS, CITY, STATE, ZIP CODE 980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	A COVID-19 focus initiated on 10/05/2 10/05/2021. The facompliance with 42 and has implement Medicaid Services Disease Control an recommended pract COVID-19. No def The total census w	ed infection control survey was 021 and concluded on acility was found to be in 2 CFR 483.80 Infection Control ted the Centers for Medicare & (CMS) and Centers for ind Prevention (CDC) ctices to prepare for icient practice was identified.		000	TITLE		(X6) DATE
LABORATOR	1 アルビア・コンドラ ウス トピウムリ	レニトレンリアアレニス ベニアベモンヒバ エイロソモン ろじげ	WIUKE		11112		(AD) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185330	B. WING			10/05/2021	
NAME OF PROVIDER OR SUPPLIER  CAMPBELLSVILLE NURSING AND REHABILITATION CENTER				1!	TREET ADDRESS, CITY, STATE, ZIP CODE 980 OLD GREENSBURG ROAD AMPBELLSVILLE, KY 42718		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments  A COVID-19 focus survey was initiated concluded on 10/05	ed Emergency Preparedness d on 10/05/2021 and 5/2021. No deficient practice 42 CFR 483.73 Emergency		0000	DEFICIENCY)		
CABUKATUK	I DIRECTORS OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	INA I UKE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 10/05/2021 100392 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE NURSING AND REHABILITA **CAMPBELLSVILLE, KY 42718** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 focused infection control survey was initiated on 10/05/2021 and concluded on 10/05/2021. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

9QH611